STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445479	A. BUILDING _____ B. WING _____	10/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GRAY	791 OLD GRAY STATION ROAD GRAY, TN 37615

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F 000	INITIAL COMMENTS An onsite visit was conducted on October 4, 2010, through October 6, 2010, to complete the annual survey and to investigate complaint # 26204, and # 26223. No deficiencies were cited related to the complaints.	F 000	This plan of correction constitutes our written allegations of compliance. "This plan of correction is submitted as required under the federal and state regulations and statues applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan dose not constitute agreement by the facility that the surveyors findings on conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied."	11/2/10
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced	F 164	F 164 483,10(e) 483.75 (I)(4) **Personal and Privacy /Confidentiality of Records** SS=D **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 1 was immediately provided privacy. CNA's involved in the incident immediately received one on one re-educated on providing privacy to residents during personal care. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. Nurses and CNA's will be re-educated on providing privacy to residents during personal care by the Staff Development Coordinator, Director. Completed by November 1st 2010.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RN I.E.D. — RN Interim Executive Director — 10-19-10

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F 164	Continued From page 1 by: Based on medical record review, observation and interview the facility failed to maintain privacy for one (#1) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on April 6, 2007, with diagnoses including Advanced Dementia, Congestive Heart Failure, Osteoporosis, and Hypertension. Medical record review of the Minimum Data Set dated March 11, 2010, revealed the resident had short and long term memory problems, required moderate assistance with decision making, and total assistance with all activities of daily living. Observation, during the initial tour, on October 4, 2010, at 9:55 a.m., revealed the door to the resident's (#1) room was closed. This surveyor knocked on the door and a certified nursing assistant (CNA #1) stated, "Come in." When the door was opened, observation revealed the CNA providing personal care without having the privacy curtain closed. The resident's buttocks were exposed. Continued observation, at that time, revealed another resident in the room and the privacy curtain between the residents was not closed to allow privacy for the resident. Interview with a Licensed Practical nurse (#1) on October 4, 2010, at 10:00 a.m., in the resident's room confirmed privacy was not provided for the resident.	F 164	**What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Nurse and CNA's will be r e-educated on providing privacy for residents during personal care by the Staff Development Coordinator. Providing privacy for residents during personal care will be part of orientation for new CNA's and Nurses which will be provided by the Staff Development coordinator . Completed by November 2nd 2010. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? What quality assurance program will be put into place?** The unit managers, assistant director of nursing, RN supervisor or staff development coordinator will randomly monitor nursing staff on all shifts giving residents personal care. 3 Nursing personnel per week will be monitored. Findings of audits will be taken to the PI meeting by the DON which will be held on November 2nd. 2010.	11/2/10
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if	F 176		

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F 176	Continued From page 2 the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, it was determined the facility failed to assess one resident (#9) of twenty-seven residents reviewed for self-administration of medications. The findings included: Resident #9 was admitted to the facility on February 1, 2010, with diagnoses including Dementia with Behavioral Disturbance, Depressive Disorder, Psychosis, Anxiety, and Senile Dementia. Medical record review of the Minimum Data Set (MDS) dated July 24, 2010, revealed the resident had moderately impaired cognitive skills. Medical record review revealed no documentation the resident had been assessed for self-administration of medications. Observation and interview on October 4, 2010, at 10:00 a.m., revealed an open, single-use packet of antibiotic ointment, lying on top of a chest-of-drawers at the resident's bedside. The resident confirmed, "...The nurse gave it to me (antibiotic ointment)...I put it on my sore (resident pointed to a dime-size area on face below the resident's left eye)...when I run out the nurse brings me more..."	F 176	**F 176 483.10(n) Resident self administer drugs if deemed safe.** **SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #9's MD was contacted regarding the use of the antibiotic ointment to face The MD discontinued the ointment. Resident and family was made aware that resident no longer needed the ointment. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. Each resident's rooms were immediately observed for medications at beside. No other residents were found to have medications at bedside. **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Nursing staff will be re-educated on the self administration of medication policy. Nursing staff will be educated during initial orientation as well. Education will be given by the Staff development coordinator and will be completed by November 2nd, 2010 . **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? What quality assurance program will be put into place .** Nursing staff will be monitored during med pass to ensure no medications are left at bedside unless resident has been deemed appropriate for self administration by the Unit Manager. The resident's rooms will be monitored for medications at beside. 3 nurses per week will be monitored. The results of the audits will be taken to the PI meeting by the DON beginning November 2nd 2010	11/2/10

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F 176	Continued From page 3 Interview with Licensed Practical Nurse (LPN) #1 on October 4, 2010, at 10:35 a.m., at the 400 Hall Nursing Station, confirmed the facility failed to assess the resident for self-administration of medications.	F 176	**F281 483.20(k)(3)(i) Services Provided Meet Professional standards.** **SS=D**	11/2/10
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow physician's medication orders for one (#6) of twenty-seven sampled residents. The findings included: Resident #6 was admitted to the facility on September 8, 2008, with diagnoses including Dementia, Depressive Disorder, and Dysphagia. Medical record review revealed a physician's order dated September 8, 2010, for Celexa (antidepressant) 40 mg. (milligrams) (decreased from 60 mg. daily). Review of the Medication Administration Record (MAR) for September 2010, revealed no documentation the resident received the medication on September 27, 28, 29, and October 3, 2010. Medical record review of the MAR dated October 2010, revealed the resident received Celexa 60 mg. on October 1, 2, and 4, 2010. Interview with the Director of Nursing, in the	F 281	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 6's MD was notified that resident had not received dosage of celexa for September 27th – 29th and October 3rd and that the dosage received for October 1st 2nd and 4th was 60 mg. No new orders were received. Medication dosage was correct on MAR. **Residents identified as having the potential to be affected by the same deficient practice.** **What corrective actions will be taken?** All residents in the facility have a potential to be affected. Nursing staff will be re-educated on ensuring that medications given are signed off on the MAR by the Staff Development Coordinator. Re-educate Medical Records Director on protocol for inputting orders into the computer and initialing orders when they are inputed. Completed by November 2nd, 2010 **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Nurses will be re-educated by the staff development coordinator to check MARS prior to end of shift to ensure that all medications that have been given are signed off on the MAR. Unit mangers will check MARS daily to ensure MARS are without omissions. The Director of Nursing will receive a copy of all medication orders that have been entered into the computer system daily with initials on orders.	

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F 281	Continued From page 4 conference room, on October, 5, 2010, at 3:30 p.m., confirmed no documentation the resident received the medication on September 27, 28, 29, and October 3, 2010. Further interview confirmed the resident received the incorrect dosage of Celexa on October 1, 2, and 4, 2010.	F 281	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur? What quality Assurance program will be put into place?** MAR's will be audited by the Unit Managers daily to ensure that medications that are given have been signed off. The DON will check 3 medication order entries daily to ensure they have been inputted into the computer correctly. November 2^{n} , 2010.	11/2/10
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain laboratory results as ordered by the physician for two (#4 & #6) of twenty-seven sampled residents. The findings included: Resident #4 was re-admitted to the facility on August 19, 2009, with diagnoses including Encephalopathy, Multiple Sclerosis, and Psychosis. Medical record review revealed a physician's order dated August 19, 2009, for Depakote 500 mg. (milligrams) every twelve hours. Medical record review of Physician's Standing Orders revealed, "Lab Orders ...Depakote level every 6 months." Medical record review revealed no documentation the labs had been obtained since the physician order date of August 19, 2009.	F 502	**F 502 483.75 (i)(1) Provide/Obtain Laboratory SVC-quality timely SS=D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #4 's MD was notified and depakote level was drawn immediately and placed on resident tracking log for every 6 months. Resident #6 MD was notified and order for labs were discontinued. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. Unit managers will be re-educated by the DON on making sure that residents labs are logged on calendar. Lab calendar will be checked daily. Residents lab tracking logs will be checked daily to ensure labs are drawn as ordered. Education completed on October 18th 2010by the Regional Director of Clinical Services. . **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Lab calendar will be checked daily labs due list will be reviewed in morning clinical meeting. Started on October 7th 2010	

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F 502	Continued From page 5 Interview with Regional Director of Clinical Services, in the conference room, on October 5, 2010, at 4:00 p.m., confirmed the labs had not been obtained as ordered by the physician on August 19, 2009. Resident #6 was admitted to the facility on September 8, 2008, with diagnoses including Dementia, Dysphagia, and Osteoporosis. Medical record review of a physician's order dated August 14, 2009, revealed, "Tranferrin, Albumin, Pre-Albumin and Total Protein level every 3 months." Medical record review revealed the lab was obtained on January 8, 2010, with abnormal results reported to the physician of total protein 5.5 low (normal 6.4-8.3), albumin 3.1 low (normal 3.2-4.6) and pre-albumin 16.5 low (normal 18.0-45.0). Medical record review revealed no documentation the labs were obtained in April or July, 2010. Interview with the Regional Director of Clinical Services, in the conference room, on October 5, 2010, at 4:00 p.m., confirmed the labs had not been obtained every three months as ordered by the physician.	F 502	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** DON, ADON, or RN supervisor will audit 3 residents chart from each unit weekly and ensure all labs are being obtained as ordered. The DON will take results of audits to the monthly PI meeting beginning with PI meeting on November 2nd 2010.	11/2/10

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